

Clear Resolutions Inc.

An Independent Review Organization
6800 W. Gate Blvd., #132-323
Austin, TX 78745
Phone: (512) 879-6370
Fax: (512) 519-7316
Email: resolutions.manager@cri-iro.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Feb/19/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: I/P L5-S1 ALIF w/2 day LOS

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., Board Certified Orthopedic Surgery with fellowship training in Spine Surgery

REVIEW OUTCOME: Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute. It is the opinion of this reviewer that the request for an I/P L5-S1 ALIF w/2 day LOS is not recommended as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
MRI of the lumbar spine 01/16/13
Clinical note dated 01/23/13
Clinical note dated 02/06/13
Clinical note dated 03/27/13
Clinical note dated 04/23/13
Clinical note dated 05/15/13
Clinical note dated 06/20/13
Clinical note dated 09/18/13
Clinical note dated 01/10/14
X-rays of the lumbar spine dated 03/26/13
Behavioral medicine evaluation dated 07/10/13
Electrodiagnostic studies dated 01/23/13
Adverse determinations dated 12/06/13 & 01/10/14

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who reported an injury regarding his low back when he subsequently fell backwards resulting in an immediate onset of right sided low back pain. The MRI of the lumbar spine dated 01/16/13 revealed a slight loss of discal signal intensity due to a disc desiccation at L5-S1. A high signal intensity zone was noted at the posterior aspect of the annulus on the right secondary to an annular tear with a focal disc protrusion with obliteration of the epidural fat and impingement on the right S1 nerve root. The electrodiagnostic studies completed on 01/23/13 revealed essentially normal findings. No radiculopathy was noted. The clinical note dated 02/06/13 indicates the patient having complaints of right sided low back pain. The patient described the pain as an aching, cramping, sharp, stabbing, burning sensation that was noted to be constant in nature.

The note mentions the patient having previously undergone medications, rest, and physical therapy with no significant benefit. The note mentions the patient utilizing Tramadol for pain relief. Upon exam, sensation was noted to be intact to light touch and pin prick testing. No strength deficits or reflex changes were noted. The x-rays of the lumbar spine dated 03/26/13 revealed diffused degenerative disc disease involving all lumbar interval disc spaces. No evidence of anterior listhesis or retrolisthesis or spinal instability was noted. The clinical note dated 03/27/13 indicates the patient continuing with low back pain. The note mentions the patient utilizing a Medrol dose pack, Celebrex, Zanaflex, and Norco for pain relief.

The clinical note dated 04/23/13 indicates the patient having complaints of low back pain with radiation of pain across the hips and into the right lateral thigh. The patient rated the pain as 6-10/10 at that time. The clinical note dated 05/15/13 indicates the patient having undergone counseling for smoking cessation. The patient was considered for a fusion at L5-S1 at that time. The clinical note dated 06/20/13 indicates the patient having undergone an injection with no significant benefit. The behavioral medicine evaluation dated 07/10/13 indicates the patient's scores from a battery of psychological tests have predicted a poor outcome from medical or surgical intervention. The note mentions the patient likely benefitting from psychotherapy and an adjustment in possible pain control. The clinical note dated 09/18/13 indicates the patient continuing with complaints of low back pain with radiation of pain into the lower extremities. The patient was recommended for a surgical intervention at that time.

The utilization review dated 12/06/13 resulted in a denial as no evidence of disc space collapse, motion segment instability, or severe spondylolisthesis were noted on the flexion and extension views of the lumbar spine. No objective findings were noted indicating a lumbar radiculopathy.

The utilization review dated 01/10/14 resulted in a denial as no findings were submitted confirming the patient's radiculopathy in the L5-S1 distributions. Additionally, the lumbar x-rays revealed no significant findings that would indicate a likely benefit of a surgical procedure.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The documentation submitted for review elaborates the patient complaining of ongoing low back pain with radiation of pain to the lower extremities. A fusion would be indicated in the lumbar region provided the patient meets specific criteria to include significant findings noted on the flexion and extension view x-rays as well as clinical exam findings confirm the patient's radiculopathy in the appropriate distribution. No information was submitted regarding significant findings confirmed by x-rays to include disc space collapse, motion segment instability, or severe spondylolisthesis. Additionally, no information was submitted regarding the patient's clinical exam findings confirming a radiculopathic component in the L5 or S1 distributions. Given these findings, the requested ALIF at the L5-S1 level is not appropriate for this patient at this time. As such, it is the opinion of this reviewer that the request for an I/P L5-S1 ALIF w/2 day LOS is not recommended as medically necessary.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

INTERQUAL CRITERIA

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

TEXAS TACADA GUIDELINES

TMF SCREENING CRITERIA MANUAL

PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)